of the face, should have vigorous cleansing methods applied before operating.

Operations cannot always be done upon selected patients. Many operations are forced upon the surgeon—*e. g.*, patients suffering from chronic nephritis or diabetes, etc.

White's plan of preparing the patient for operation has shown its efficacy in the hands of various operators. In more than 500 extractions done at the Richmond Infirmary, there was only 1 case of infection, and that was mild. The method consists in the bath and purgative; the face is washed with 1: 1000 bichloride solution, and finally with alcohol. The conjunctival sac is thoroughly irrigated with 1:10,000 and filled with bichloride vaselin (mercury bichloride, 1 gr.; sodium chloride, 5 gr.; boiled vaselin, 6 oz.). The free use of the ointment is claimed to be an effective protection against infection from without.

The preparation of the instrument and their maintenance in an aseptic condition during the entire time of the operation is, of course, a matter of supreme importance.

The signs of beginning infection resemble those of spongy iritis, from which it must be differentiated. In iritis the upper section of the cornea becomes hazy, the anterior chamber shallow, the iris swollen and hyperæmic, and the anterior chamber is partly filled with a dark mass of spongy exudation. Infection appears as a white point in the line of incision, rapidly spreading until the whole cut is a dense white line sharply outlined against the comparatively clear cornea. The anterior chamber is at first clear and later occupied by a dull white mass suspended in its upper section or protruding through the pupil. The wound may be closed or open, usually the former, because the devitalized condition of the eye and the direct cause of the infection acting in conjunction prevent closure. The edges of the incision may unite before the septic process is fairly under way, when the anterior chamber is reformed and maintains its normal depth, at least for some time.

After infection has occurred, while the outlook is bad, it is not hopeless. Local treatment consists in cauterization of the wound, subconjunctival injections and germicides inserted or injected into the anterior chamber. The cauterization is accomplished by means of the galvanocautery, silver nitrate, mercuric bichloride, carbolic acid, and the thermocautery. Darier declares that the last should not be used. He is the special advocate of subjunctival injections, the value of which, however, still remains to be determined. The insertion of iodoform in rods or disks containing up to 70 per cent. of the remedy are unquestionably of service if introduced early enough, the earlier the better. The injection of other substances than iodoform has received little attention, though bichloride, 1:1000, has given good results. Hansell reports a strikingly satisfactory case where this method was employed with the saving of useful vision.

In all cases the general treatment should be stimulating and supporting.

Peritomy for Diffuse Corneitis and Other Affections of the Cornea.—SNELL, Sheffield (*Ophthalmology*, April, 1905), from experience in over 200 cases, advocates this operation in certain diseases of the cornea; it consists in removing a band of conjunctiva, 2 to 3 mm. in width, all around the cornea; in a few cases he has practised a partial peritomy opposite a particular portion of the cornea, which it was specially desired to affect, but the complete operation is to be preferred.

The operation may be employed as a routine treatment in diffuse corneitis, and may be expected often to materially shorten the duration of this disease with more complete recovery of transparency. It may also be used advantageously in a variety of other corneal affections, especially recurring ulcers of the cornea. The operation appears to be free from danger.

Full Correction of Myopia.—BOURGEOIS, Reims (*Arch. d'Ophthal.*, May, 1905), in a paper read before the Société Française d'Ophthalmologie, advocates full correction of low and moderate degrees of myopia, especially in young subjects. These form about two-thirds of the total number of myopes. For the higher grades of myopia above 12 D. there is no general rule, each case to be decided by itself. In some young subjects partial corrections gradually increased until the full is reached will often be successful.

Until about twenty years ago oculists had very generally recommended partial correction of all cases of myopia above low degrees. Since then the subject has been largely worked over by oculists of all countries. One of the most recent publications is that of Sattler, in 1904, reviewing the work of most previous writers, and recommending full correction.

Those who have practised full correction have established the fact that this method exerts a beneficial influence upon the further progress of the myopia, arresting or retarding its increase. It is accordingly especially important to prescribe such correction at the beginning, when the error is still low. This is no doubt true of the myopia caused by prolonged near work; but it is not yet proved that it also holds good in malignant or dangerous myopia; this must be treated as regards correcting glasses with great prudence.

There are two methods: full correction at once, best applied in young subjects whose myopia is of low degree, and progressive increase in the strength of the correcting lens in the higher degrees.

The writer holds that cases of myopia up to 1 D. in young subjects will do well with the full correction; when thus early discovered and corrected these cases never increase. Even up to 3 D., the full correction is well borne in young subjects. For the general application of such correction a careful examination of the eyes of all school children must be made by competent oculists. The indiscriminate sale of glasses should be regulated by law, since children who are provided with glasses for their myopia without competent examination almost always select an overcorrection, especially in low degrees of myopia.

The writer rightly holds that skiascopy is the most exact and rapid method of determining the refraction in myopia; but he is wrong, as we believe in thinking that this can be safely done without a mydriatic. If practised in this way the patient's accommodation will lead to overestimation of the refraction in many cases in young subjects. Astigmatism is also, of course, to be carefully considered in the prescription. Anisometropia must receive proper attention; the accurate adjustment of the lenses before the eyes is no less important. Where insufficiency of convergence is present, it may be compensated by decentration of the glasses.